

# MISSOURI DIVISION OF HEALTH—STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033328

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 314 Primary Registration District No. 4459 Registrar's No. 47

FILED AUG 26 1963

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
1 0930		
2 0930		
3		
4 0		
5 0		
6		
7 0		
8 0		
9 420.1		
10		
11		
12 90-0		
13 2-0		
ITEM NO.	SHOULD READ	BY AFFIDAVIT OF

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Clair	
b. CITY (If outside corporate limits, give TOWNSHIP only) Osceola		c. CITY OR TOWN Osceola	
Length of stay in 1b Years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) Charles M. Cooper		4. DATE OF DEATH August 9, 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/2/96-66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trader		10b. KIND OF BUSINESS OR INDUSTRY Live Stock	
11a. FATHER'S NAME William Cooper		11b. BIRTHPLACE (City and state or country) St. Clair County Mo; USA	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW# 1		12b. SOCIAL SECURITY NO. [redacted]	
13a. MOTHER'S MAIDEN NAME May Ledbetter		13b. NAME OF HUSBAND OR WIFE George Cooper, Appleton City Mo.	
14. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH instant.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)	
DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY. Hour a.m. p.m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from July 55 to Aug 63 and last saw her alive on June 63 Death occurred at 11:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE [Signature] M.D.	
22b. ADDRESS Osceola Missouri		22c. DATE SIGNED 8/10/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/12/63	
23c. NAME OF CEMETERY OR CREMATORY Osceola Missouri		23d. LOCATION (City, town, or county) (State) Osceola Missouri	
24. FUNERAL DIRECTOR Goodrich Funeral Home, Osceola Mo.		25. DATE RECD. BY LOCAL REG. 8-13-1963	
26. REGISTRAR'S SIGNATURE [Signature]			

AUG 21 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
for by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Paul J. [Signature]*

Licensed Embalmer No.

3990

P. O. Address

Orceola, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.